Date: _____

APPLIED SOMATICS

Client Intake Form - Please Print Clearly

Last Name: _____

First Name: _____

Gender : M____ F_____ Other _____

Phone: _____

Cell Phone _____

Work Phone: _____

Address: _____

City/Town: _____

Province: _____

Postal Code: _____

Birth Date: _____

Occupation: _____

Email : _____

Would you like receive email updates? Yes, No

How did you hear about the clinic?_____

_____

What are your goals concerning your treatment at Duncan Wellness Centre ?

_____

_____

By my signature below, I authorize collection, use and disclosure of personal information, as defined in the Personal Information and Privacy Act (PIPA), required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential, and must be treated in accordance with PIPA.

I also agree that a **NO SHOW FEE** equivalent to the time booked with the therapist (e.g. 1 hour session = $100.00, 45 min. session = $80.00, etc.) will be billed when appointments are missed or cancelled with less than 24 hours notice:

Signature: _____

Date: _____

MEDICAL INFORMATION

Care Card Number:_____

Family Doctor:_____

Dr. Phone # _____

Referring Dr .(if different):_____

Referring Dr. Phone #_____

Other Healthcare Professionals seen for this condition:_____

How many other visits have you made this year with RMTs, Physios and/or Chiropractors_____

	Past	Present	Family
Heart Condition	☐	☐	☐
Circulatory Disorder	☐	☐	☐
Pregnant	☐	☐	
Digestive Disturbance	☐	☐	☐
Skin Condition	☐	☐	☐
Sprain/Strain	☐	☐	
Head Injury	☐	☐	
Hypothyroid/Hyperthyroid	☐	☐	☐
Seizures	☐	☐	☐
Epilepsy	☐	☐	☐
Respiratory Problem	☐	☐	☐
Surgery	☐	☐	☐
Fracture/Broken Bone	☐	☐	☐
Cancer	☐	☐	☐
Contagious Disease	☐	☐	☐
Diabetes	☐	☐	☐
Eating Disorder	☐	☐	
High/Low Blood Pressure	☐	☐	☐
Liver Disease/HIV/Aids/Hepatitis	☐	☐	☐

Dominance (L=Left, R=Right, N=Neither, Unsure = ?):

Hand: _____Leg: _____ Eye: _____

Doctor Recommends Supervised Exercise Only ☐

Allergies *(specify)*: _____

Any other medical conditions:_____

_____

~ Please See Reverse ~

APPLIED SOMATICS
Client Intake Form - page 2

Main Complaint _____

When and how did it happen?_____

Description of Pain _____

What aggravates it? _____

What relieves it? _____

Interferes with daily activities? Yes _____ No _____ (please check)

Stress Level (1 - 10) _____ (1 is very low and 10 is very high) Energy Level (1 - 10) _____

Dietary Habits _____ (1 is very poor and 10 is excellent) Would like to improve dietary habits? yes / no (please circle)

Fitness Level (1-10) _____ (1 is very poor and 10 is excellent) Would like to improve fitness level? yes / no (please circle)

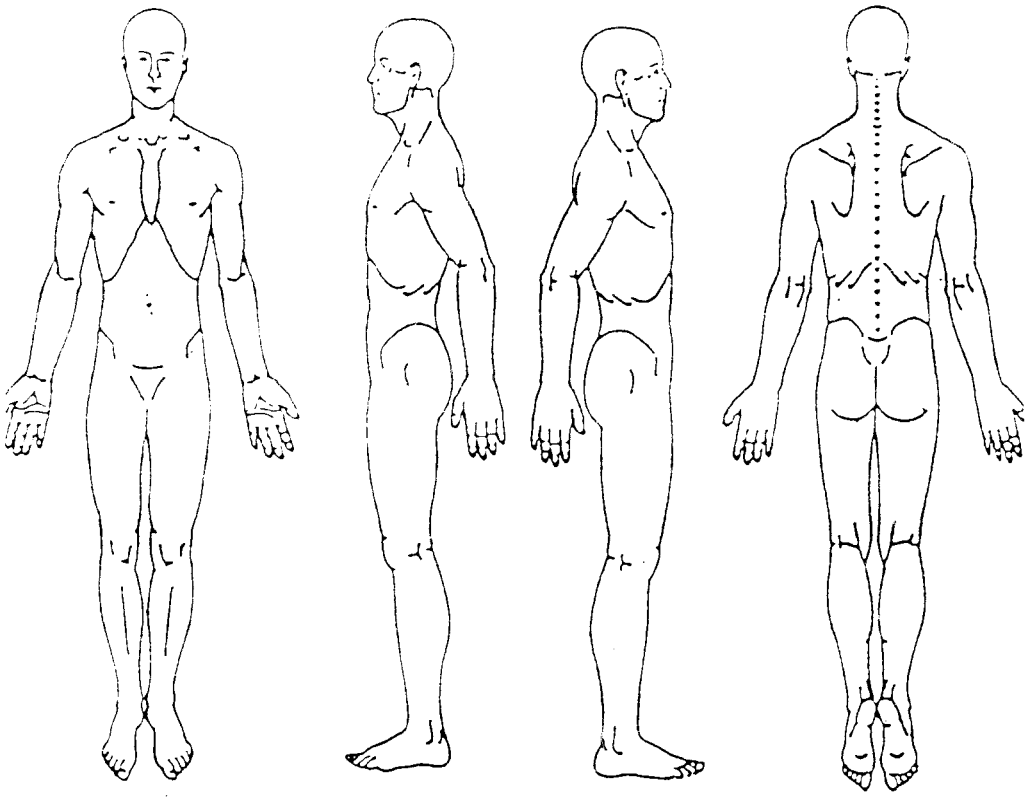
Fitness Activities _____

Smoke ☐ Consume alcohol? ☐ Cups of Coffee/Day _____ Glasses of Water/Day _____

Adequate Sleep? yes / no Hours of sleep per day ____ Overall Health (1-10) _____ (1 is very poor and 10 is excellent)

Medications _____

On the diagram below, please circle any areas of discomfort and nearby indicate a number between 1-10 that corresponds to the level of discomfort with 1 being very little discomfort and 10 being extreme discomfort.



WCB/ICBC

WCB Claim #: _____ ICBC Claim # _____

Lawyer: _____ Lawyer's Phone #: _____